STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155711	A. BUILDING _____ B. WING _____	C 11/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR HEALTHCARE	2926 N CAPITOL AVE INDIANAPOLIS, IN 46208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the investigation of complaint numbers IN00099648 and IN00099720.

Complaint number IN00099648: Substantiated, no deficiencies related to the allegations are cited

Complaint number IN00099720: Unsubstantiated due to lack of evidence

Dates of survey: November 21 and 22, 2011

Facility number: 000567
Provider number: 155711
AIM number: 100289560

Survey team:
Vanda Phelps, RN, TC
Michelle Hosteter, RN

Census bed type:

SNF	1
NF	13
SNF/NF	29
Total	43

Census payor type:

Medicare	1
Medicaid	42
Total	43

Sample: 3

Highland Manor Healthcare was found to be in compliance with 42 CFR part 483, subpart B and 410 IAC 16.2 in regard to the investigation of complaint numbers IN00099648 and IN00099720.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 1 Quality review completed 11/27/11 Cathy Emswiller RN	F 000		